VERMONT
DEPARTMENT OF HEALTH

Vermont Title V Maternal and Child Health Block Grant Needs Assessment Summary

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Overview of the Process

Vermont's approach to the Title V needs assessment is focused on both the strengths and needs of the state's Maternal and Child Health (MCH) systems and populations. Since 2005, we have employed a life course approach to public health and recognized the overarching impact of social determinants on population health. The transformation of the MCH Block Grant process aligns well with our MCH community's longstanding approach and philosophy.

The overall direction for Vermont's 2015 Title V needs assessment was provided by the MCH Leadership Team. Members of the team represented a broad cross section of programs including: WIC, home visiting, early childhood, family planning/preconception health, Early Periodic Screening Diagnosis and Treatment (EPSDT)/school and adolescent health, Children with Special Health Needs (CSHN), injury prevention, epidemiology, and Vermont Family Network (VFN). The team provided input on the

assessment process, including identification of stakeholders to participate in key informant interviews, review of data as well as the prioritization and action planning processes.

Two broad sources of information were used to underpin the 2015 needs assessment: 1) review and analysis of public health surveillance data; and 2) qualitative data collected through a series of key informant interviews and group discussions with MCH stakeholders. Input was received from MCH coordinators, parent child centers, public health professionals, school liaisons, medical providers, human service providers (e.g. early childhood), parent representatives (VFN) and state programs. Forty stakeholders representing each of six MCH population domains and 15 priority areas participated in a total of 23 individual interviews or group discussions. These interactions were designed to explore, (i) the availability and quality of MCH systems and supports, (ii) strengths and challenges of each population domain and priority areas and, (iii) opportunities for improvements and/or assets to be leveraged. Quantitative analysis was conducted internally at the Department of Health, led by Vermont's State Systems Development Initiative (SSDI) analyst. Key informant interviews were completed under contract with JSI Research and Training Institute.

Quantitative data was drawn from the following data sources: National Vital Statistics System (NVSS), Vermont Vital Statistics, National Immunization Survey (NIS), Pregnancy Risk Assessment Monitoring System (PRAMS), Behavior Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), National Survey of Children's Health (NSCH, National Survey of Children with Special Health Care Needs (NS-CSHCN), and inpatient hospitalization data. Data were analyzed for the population, as a whole, as well as stratified by age, race/ethnicity, gender, insurance status/type, education, income, urban/rural, among other demographics. Medicaid claims data, program-level data (e.g. home visiting), and quality improvement data from chart audits (e.g. adolescent well visits, developmental screening) were also taken into consideration in the process.

These data sources are known to have a number of limitations. Firstly, because Vermont is a small state with a relatively small population, data obtained from surveys need to be interpreted with caution when large confidence intervals result. Secondly, survey data is based on self/parent-report and may be limited by parental understanding and memory of certain events (e.g. developmental screening). Data from practice improvement chart audits sometimes demonstrate dramatically different rates when compared to national survey data. Additionally, vital statistics and hospitalization data for Vermont residents may include events/births that occurred at out-of-state hospitals. Historically, New Hampshire, in particular, has been slow in sharing data with the Vermont Health Surveillance unit, potentially resulting in incomplete population estimates.

Over the course of several months, the MCH Leadership Team conducted a comprehensive review of the quantitative data and findings from the key informant interviews. Each member of the Team ranked priority areas and National Performance Measures according to the following criteria: 1) *impact* (incidence and prevalence; long-term outcomes; disparities; preventable/actionable; room for improvement; public health benefit; potential for increased/enhanced collaboration); and 2) *feasibility* (subject matter competency; political and organizational will; resource availability; alignment with mission; availability of partners/external resources; synergy effect between priorities; evidence-based or –informed strategies). Following this individual ranking process, scores were compiled and a list of top priorities emerged. The MCH Leadership Team was largely unanimous in our decision making. Only small shifts in the priority areas were made in cases where there wasn't complete agreement among Team members or where there wasn't adequate alignment with the six population domains.

Lastly, the Leadership Team was asked to rank priority areas that emerged from the key informant interviews and our current work that were not evident in the 15 National Performance Measures, such as: mental health, substance abuse, domestic and sexual violence, youth empowerment, family/consumer partnerships, alcohol use, immunization, and chronic disease. The top priority areas that emerged from this process will be used to inform the next round of State Performance Measures.

Once this process was complete, small teams of MCH staff working within each population domain developed an action plan for each priority area/performance measure. Vermont's final list of priority areas and performance measures are listed below.

Vermont MCH Priority Areas and Performance Measures

Population domain: Women's/Maternal Health

Priority area:	Ensure optimal health prior to pregnancy
Performance measure:	Percent of women with a past year preventive medical visit

Population domain: Perinatal/Infant Health

Priority area:	Promote optimal infant health and development
Performance measures:	Percent of infants who are ever breastfed
	Percent of infants breastfed exclusively through 6 months

Population domain: Child Health

Priority area:	Achieve a comprehensive, coordinated, and integrated state and community system of services for children
Performance measure:	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Priority area:	Children live in safe and supported communities
Performance measure:	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19

Population domain: Children with Special Health Care Needs

Priority area:	Achieve a comprehensive, coordinated, and integrated state and community system of services for children
Performance measure:	Percent of children with and without special health care needs having a medical home

Population domain: Adolescent Health

Priority area:	Youth choose healthy behaviors and thrive
Performance measure:	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Priority area:	Youth choose healthy behaviors and thrive
Performance measure:	*State performance measure, to be determined*

Population domain: Lifecourse/Cross-cutting

Priority area:	Reduce the risk of chronic disease across the lifespan
Performance measures:	Percent of women who had a dental visit during pregnancy Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Priority area:	Reduce the risk of chronic disease across the lifespan
Performance measures:	Percent of women who smoke during pregnancy Percent of children who live in households where someone smokes
Priority area:	Promote protective factors and resiliency among Vermont's families
Performance measure:	*State performance measure, to be determined*
Priority area:	Achieve a coordinated mental health system for children, youth, and pregnant women
Performance measure:	*State performance measure, to be determined*

Review of MCH Population Needs

The Needs Assessment findings are organized by population domains and associated National Performance Measures and discussed on the following pages.

Women and Maternal Health

Well Woman Care. In 2013, 66.7% of Vermont women reported having a preventive medical visit during the previous year, slightly better than the U.S. rate of 65.2% (BRFSS). Women with health insurance reported a significantly higher visit rate of 70.2% compared to 37.2% reported by women who lacked insurance. Women aged 18-24 years were more likely to have had a preventive medical visit than other age groups. Compared to 64.5% of U.S. women overall, 77.3% of Vermont women 18-24 years of age said they had a visit. However, the U.S. overall did better in the 35-44 year age group with a rate of 67.5% compared to the Vermont rate of 62.0%. For women 25-34 years of age, the Vermont visit rate of 61.8% also was slightly worse than the U.S. rate of 63.5%.

With the roll-out of the Patient Protection and Affordable Care Act (ACA) and the State's commitment to addressing insurance as a barrier to care, key informants commented that, in Vermont, coverage was not the predominant issue that determined access. Lack of knowledge and understanding of the recommended clinical guidelines and periodicity of screenings or exams, such as Pap tests for cervical cancer screening and mammograms for breast cancer screening, were regarded by informants as a more significant barrier. While programs such as *Ladies First* are able to successfully target a specific segment of the population, clearly more work needs to done to reach other populations. Key informants suggested improved messaging around well woman care in multiple settings including family planning, WIC, and during perinatal home visits. Surveillance data indicate that efforts to improved messaging to Vermont women about preventive health care should be focused primarily on the 25-44 year age group.

Low Risk Cesarean Deliveries. Between 2009 and 2013, Vermont experienced a gradual decline in the rate of cesarean deliveries among low risk first births (National Vital Statistics System). The national target rate for low-risk cesareans is 23.9%. In 2012, Vermont's rate was slightly better than the national target, and by 2013 Vermont's rate fell to 22.5% compared to a U.S. rate of 26.8%. Key informants attribute this decline, in part, to: 1) improved knowledge about the risks of elective cesarean and induction amongst health care providers and women across the state; and 2) quality improvement (QI) and policy work facilitated by the Vermont Child Health Improvement Program (VCHIP) and others in recent years. In addition, almost all (11 out of 12) birthing hospitals in the state participated in a project to develop policies and procedures to eliminate elective inductions prior to 39 weeks gestation. Both initiatives demonstrate that a centralized vision and organized effort to establish a common goal have the potential to change policy and practice. This model continues to be applied to other MCH initiatives. For example, access to vaginal births after cesareans (VBAC) continues to be a challenge in Vermont, particularly in rural areas. Here, the legal climate in some of the smaller community hospitals may produce roadblocks to improvement. VDH collaborates with the Northern New England Perinatal Quality Collaborative to champion this issue and to support hospitals through a QI framework. This process is seen as pivotal to achieving progress in this area. Other strategies to address low risk cesarean delivery include use of doulas. Vermont efforts are underway to promote and establish Medicaid reimbursement for doula care.

Vermont still has unmet goals for engaging additional partners to improve women's and maternal health. Outreach and engagement with prenatal care professionals such as obstetricians and nurse midwives continues to present a challenge. We need to further develop a professional network of prenatal care providers, such as a Vermont chapter of the American Congress of Obstetricians and Gynecologists (ACOG), to facilitate better connection to this community. Improved engagement of diverse populations and cultures is another area that stakeholders identified for improvement, particularly as it relates to late entry to prenatal care.

Perinatal/Infant Health

Perinatal Regionalization. Since 2005, Vermont's rate of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) has fluctuated, with the state's lowest rate occurring in 2006 (80.2%). The national target rate for VLBW infants born in hospitals with advanced care facilities is 83.7%. In 2009-2013, the Vermont rate was 88.7% for mothers aged 20-24 years, significantly better than the national target rate. The rate for Vermont women aged 35 years and over exceeded the national target by 14.4%, at 98.1%. By contrast, women who smoked during pregnancy were significantly less likely (75.5%) to deliver their VLBW baby at a hospital with a high-level NICU than non-smokers (90.2%), and failed to meet the national target. The University of Vermont (UVM) Medical Center in Burlington, serving Vermont's largest metropolitan population, is the state's only Level III NICU. Vermont residents living in other areas of the state commonly give birth at Level III NICUs in the bordering states of New Hampshire, New York and Massachusetts.

Key informants recognized that physician champions from UVM Medical Center have made important contributions to the state's progress in this area. These champions provided outreach to other hospitals, supporting local efforts. Several Vermont hospitals used a web-based quality assurance and improvement tool (OBNET) to track outcome data on births (e.g., non-medically indicated inductions prior to 39 weeks, births under 34 weeks, etc.). Monitoring data to inform areas in need of improvement and subsequent outreach to hospitals has enhanced the state's regionalization. The OBNET system platform needs upgrading, which is cost prohibitive. There is concern that with the loss of this system, improvement in

this area will be stalled or reversed. However, we are currently working on a compromise solution to continue to facilitate this work.

Another factor in the state's progress in the area of perinatal regionalization is the Comprehensive Obstetrical Services Program. Administered by the Department of Obstetrics and Gynecology at UVM Medical Center, the program provides comprehensive, team-based, maternity care to women who are socially or economically at-risk. The care coordination team includes an obstetrician, a social worker, a nurse and a nutritionist. Services include comprehensive prenatal care, laboratory and genetic testing, birth and postpartum services, WIC enrollment, breastfeeding support, and contraception counseling. Service coordination also occurs with the NICU and with the intensive services provided to women who have chemical addictions.

Breastfeeding. Between 2007 and 2011 Vermont either met or surpassed the national target rate of 81.9% for initiation of breastfeeding.(National Immunization Survey) In 2011, 90% of infants in the state were ever breastfed, significantly higher than the overall U.S. rate of 79.2%. Vermont women with a college education exceeded the target rate even further at 95.6%. High rates of breastfeeding were consistent across all income levels. For Vermont residents with incomes 200%-399% of the federal poverty level, the breastfeeding rate was 91.3%, and for those at 400%-599% of poverty the rate was 92.0%. The percent of Vermont infants exclusively breastfed through 6 months (29.6%) also exceeds the U.S. rate (18.8%) in all years, but it is not significantly better than the HP2020 target rate of 25.5%.

Key informants recognized that Vermont ranks well on breastfeeding initiation, and attributed this in large part due to QI work performed with hospital and prenatal providers. However, they noted that the duration of breastfeeding is negatively impacted when women go back to work, which may make continuation of breastfeed more challenging. The Vermont Department of Health promotes breastfeeding as an obesity prevention strategy and provides funds for training and the development of spaces within small businesses to support breastfeeding or pumping breast milk. The Health Department's home visiting programs and WIC program are proven strategies to improve breastfeeding initiation and duration. Vermont has several initiatives underway to assist hospitals, healthcare providers, and businesses to support families in reaching their breastfeeding goals, such as the 10 Steps Project (a QI project to implement evidence-based practice at Vermont birth hospitals) and peer counselors.

Safe Sleep. The Vermont back-to-sleep rate of 84.1% is significantly better than both the U.S. rate (74.3%) and the HP2020 target of 75.9%. (Pregnancy Risk Factor Surveillance System, 2011) There are no significant differences across years in Vermont.

Although the Vermont Department of Health does not have a single program dedicated to promoting infant safe sleep, key informants described various resources and diverse activities within Vermont that address safe sleep practices. MCH Coordinators at Health Department district offices provide outreach and education on safe sleep practices via community presentations. VCHIP works with hospitals throughout the state on developing polices and protocols on safe sleep practices within the hospital setting. In addition, the Health Department Child Care Wellness Consultant program advises child care providers on safe sleep practices. The state also has a well-trained medical examiner system that takes steps to identify infant deaths due to unsafe sleep practices and to distinguish these from sudden infant death syndrome (SIDS). This approach has improved the data and contributed to a better understanding of the underlying causes associated with unexpected infant deaths in Vermont. Yet, key informants also described challenges that include lack of good data and inconsistent public health messaging on safe sleep practices. Key informants commented that some breastfeeding advocates promote co-sleeping as a

strategy to improve breastfeeding duration, confusing messaging and knowledge on safe sleep practices. The Health Department is working with MCH Coordinators and the Medical Examiner on strategies to promote safe sleep that include enhancing data capacity and implementing a safe sleep program with targeted messaging.

Child Health

Developmental Screening. In 2011-2012, the National Survey of Children's Health reported a screening rate of 32.1% in Vermont, compared to the U.S. rate of 30.8%. For both Vermont and U.S., the screening rate was significantly higher in 2011-2012 than in 2007 (NSCH). The data showed no significant health disparities in screening rates. Key stakeholders, however, believe that the screening rate in Vermont is actually significantly higher than what is reported on national surveys. Both Medicaid claims data and data from practice improvement chart audits demonstrate dramatically different rates when compared to national survey data.

Key informants reported a substantial amount of work and energy in the state that addresses developmental screening. Vermont's efforts were described as strong in promoting consistent use of developmental screening tools. VCHIP has trained over 80 primary care practices in using validated developmental and autism screening tools. Most practices have adopted the routine use of validated tools although some variability still exists between practices. VCHIP data from chart audits indicate that only 26% of children had all three recommended developmental screens, calling attention to system gaps (Child Health Advances Measured in Practice, VCHIP 2014). The Department of Health has leveraged funding opportunities such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) Linking Actions for Unmet Needs in Children's Health program (Project LAUNCH) to pilot universal developmental screening in Chittenden County. The initiative involves training on developmental screening in medical homes and in early child care and education. This work is being expanded by VCHIP and will be rolled out statewide over the next three years. The Health Department is creating a developmental screening registry to better monitor developmental screening rates, as well as to make screening results more accessible to individual health care providers and early child care professionals.

Beyond training providers and other professionals on developmental screening, there is still an unmet need for more parental education. Providers express concern that most parents do not understand what developmental screening is, why it is done, or how the results should be interpreted. In turn, this has caused concern among parents and, for some, there is a feeling of stigma associated with a mental health diagnoses. Providers report providing a careful explanation of developmental screening increases parental receptivity. One Vermont key informant suggested promoting developmental screening to parents as a tool no different from taking their child's blood pressure. Administering the ASQ tool in a culturally sensitive way also was perceived as a challenge to obtaining accurate data. We recognize that for individuals with limited English proficiency, and for those who belong to diverse cultures, the relevancy of ASQ and other developmental screening tools may be limited.

Vermont is currently launching the Help Me Grow program (described below), designed to connect parents with developmental concerns to appropriate health care and services, as well as to administer developmental screens when necessary.

Injury Prevention. Historically, there has been a significant reduction in the overall injury rate in the state of about 8.4 cases per 100,000 children and adolescents per year. (Hospital discharge data) Males tend to

be more prone to hospitalization for injury, with an injury rate of 248.9 per 100,000 compared to 160.9 per 100,000 for females. In turn, adolescents (10-19 years) are more likely to be hospitalized than younger children, with an injury rate of 259.2 per 100,000 compared to 136.7 per 100,000 for children 0-9 years of age.

The Vermont Department of Health addresses injury prevention in both the Division of Emergency Preparedness, Response and Injury Prevention and the MCH Division. Particular attention is given to prevention of injuries from firearms, suicide, child maltreatment, farm health, and domestic/sexual violence. Key informants commented on the need for improved capacity to support injury prevention, surveillance and programming in the population in general, and among the MCH population in particular (e.g., bike safety, use of cell phones, home safety, and water safety). Increased surveillance and the production of an annual injury prevention report would facilitate ongoing needs assessment and identification of priorities.

Motor vehicle crashes continue to be the primary cause of death among adolescents. Vermont's high uptake of driver education, a graduated driver licensing law, and strong seat belt enforcement are among the measures introduced to combat this issue.

Despite recent improvements in addressing youth suicide prevention, this topic continues to be a significant area of concern in the state. The stigma associated with suicide tends to constrain the open and honest discussion needed to increase public awareness of prevention efforts. The Vermont Center for Health & Learning has implemented public health messaging campaigns such as *UMatter* and administered suicide prevention curriculum to over 110 high schools and middle schools in Vermont. VCHIP has worked with medical practices to increase provider awareness of suicide prevention programs and resources, including mental health counseling and crisis centers. Although Vermont has made gains in general concerning suicide awareness and the capacity of the state and schools in suicide prevention, this has not translated to a decrease in youth suicide attempts and deaths. Finding sufficient resources to address depression and suicidality is a major challenge. Limited availability of mental health and child psychiatry services in the state, together with issues of inadequate health insurance coverage (i.e., mental health parity), negatively impact timely access to and appropriate care. Opportunities to address mental health and suicidality more effectively include developing mandates to insurers requiring more complete mental health care coverage, and working with schools, communities, providers, and mental health agencies to create more coordinated systems of support, care, and prevention.

Physical Activity. **C**hildren in Vermont are significantly more active compared to the U.S. as a whole. In 2011-2012, 42.8% of Vermont children aged 6-11 years participated in at least 20 minutes of physical activity every day, compared to 35.6% of children nationally (NSCH). The most recent survey also showed improvement over the 2003 Vermont rate. For adolescents ages 12 through 17 years, 25.5% of Vermont youth were physically active at least 20 minutes per day compared to an overall U.S. rate of 20.5%; this difference was not quite statistically significant.

Key informants discussed the recent gains for the state in this area, including: 1) a policy adopted by the Board of Education to implement a quality standard requiring 30 minutes of physical activity before, during or after the school day for pre-K through 12th grade; and 2) incorporating several new physical activity and nutrition regulations in the early childhood regulations updated recently by the Department for Children and Families (fall 2016). The Health Department's Physical Activity and Nutrition Program works in variety of areas to promote physical activity, including: (i) health impact assessments of physical activity, (ii) administering funds to community coalitions to support policy and environmental changes

that support physical activity and food access, (iii) working with schools, school liaisons, and early childhood programs to promote physical activity during the day, and to assess and update school wellness policies.

Challenges to increasing physical activity in Vermont children and youth include: (i) the short-term nature of funding mechanisms to support specific initiatives, and (ii) the low priority given to general prevention funding to support physical activity programs. Schools are difficult to engage because they are under pressure from so many competing priorities. However, we believe better integration of physical activity into the school curriculum would have a positive impact on both academic performance and classroom management. Other challenges include lack of physical infrastructure such as sidewalks in rural communities. This, in turn, limits opportunities for physical activity, including allowing kids to walk to school. Some schools have benefited from the Safe Routes to Schools Program which provides planning and assessment assistance – although no complementary funding is available for infrastructure improvements. Additional concerns expressed by informants about inadequate physical activity amongst Vermont's children and adolescents included too much screen time and too little connectedness with the natural environment, resulting in negative consequences to health and well-being.

Lastly, interviewees noted that providers may be missing valuable opportunities to hold conversations about physical activity with children and youth during office visits. Providers indicated they receive little training in this area and have insufficient time to address the issue. Regardless, steps need to be taken to ensure that every child and adolescent identified with a BMI outside of normal range has a documented physical activity plan.

Adolescent Health

***Bullying*.** One quarter (25%) of all adolescents in Vermont reported being bullied electronically or at school in 2013 (YRBS). Females were more likely to be bullied than males, with 29% of females reporting bullying compared to 21% of males. Asian students report the lowest bullying rates. Other minority groups reported higher rates, with White students reporting an intermediate rate of bullying. Survey data indicate that bullying decreases with increasing grade. In 2013, 28% of students in 9th grade reported being bullied compared to 21% of students in grade 12 (YRBS). In a survey of Vermont parents, 7.8% of parents reported that their child bullied others, compared to 14.2% in the overall U.S. population (NSCH, 2011-2012). Both sources of estimates are likely underestimated due to underreporting.

With generally increased awareness of bullying and the long-term impacts of bullying, Vermont schools have made strides in identifying and combatting bullying behavior. Instead of using punitive approaches, such as suspension, some schools have introduced programs and interventions to help students adopt positive behaviors, such as the Positive Behavioral Interventions and Supports (PBIS) framework. School Based Health Centers, school guidance counselors, and Community Health Teams work to provide resources and counseling support to students identified as bullying or having behavior problems. Efforts also are underway to develop a school climate assessment for use in Vermont schools.

In the medical setting, providers inquire about bullying as standard of care during a well visit. Providers use various lines of questioning to inquire about bullying depending on the child's age and probe for cyberbullying among adolescents. Although providers are generally aware of the prevalence and impacts of bullying, additional resources and guidelines are needed on how to address bullying when it is identified.

Adolescent Well Visit. According to the National Survey of Children's Health, Vermont has a higher rate of preventive medical visits than the U.S. as a whole. In 2011-2012, 90.2% of Vermont adolescents had a preventive medical visit in the past year compared to 81.7% nationally (NSCH). Both groups exceeded the Healthy People 2020 target rate of 75.6%.

While Vermont does comparatively well in this area, one key informant noted that the School Nurse Report shows students in grades K-6 have an almost 100% rate of a recent primary care visits. Yet, once students reach their junior and senior year of high school, there is a significant decrease. Key informants felt that it is important to keep parents and adolescents engaged in the health care system and to ensure young people continue to access preventative care according to *Bright Futures* guidelines.

Challenges or barriers to the use and continuation of preventive medical visits include: access to health care; lack of transportation; and low priority given by parents. Providers frequently see adolescents coming in for their sports physical or for injury visits, but not for a comprehensive annual well visit. Both sports physicals and annual well visits are coded the same way for billing purposes. Some providers maximize the opportunity of a sports physical visit by completing the full adolescent well visit instead of the sports physical exam. Department of Health School Liaisons stress the importance of the well visit and explain to schools the difference between well visits and injury visits.

Adolescents who do not participate in sports are more likely to visit their health care provider only for reasons of injury or illness. Providers noted that parents often feel that if their child is healthy they don't see a need for the doctor, and that adolescents are usually not interested in having an annual well exam. Interviewees said they would like more messaging on the importance of these visits, on the benefits from the parent perspective, and on the difference between a well visit and a visit for sports clearance or injury.

Providers also felt that adolescent well visits are an important factor in maintaining engagement in the health care system and helping with transition from pediatric to adult practice. They noted that individuals who do not have well visits in late adolescence are less likely to seek care in early adulthood, leading to a gap in preventive health care in this population.

Accountable Care Organizations (ACOs) in Vermont include the adolescent well-visit as a performance measure, which we hope will promote use of this important preventive health measure. School Based Health Centers provide another opportunity to increase use of the adolescent well visit. Additionally, Vermont was among five states selected nationally to participate in the Adolescent and Young Adult Collaborative Improvement & Innovation Network (AYAH CoIIN) with a focus on increasing adolescent well visits.

Children and Youth with Special Health Care Needs (CYSHCN)

Medical Home. In 2011-2012, just over half (53.9%) of Vermont children and youth with special health care needs (CYSHCN) had a medical home. (National Survey of Children's Health) There was no significant difference between this rate and the overall U.S. rate of 46.8%. Nearly three quarters (72.6%) of Vermont children without a special health need had a medical home in 2011-2012, compared to the U.S. rate of 56.3% and the HP2020 target rate of 63.3%.

One of the tremendous strengths of the state's system of care is that most of the pediatric practices are certified medical homes. However, key informants shared the view that that there still is room for

improvement among practices, particularly in the area of care coordination. Vermont's Pediatric Learning Collaborative plays a large role in addressing this area. The Learning Collaborative is a partnership with VCHIP, Title V, CYSHCN, and a pediatrician champion. The initiative's focus is on teaching and supporting pediatric practices on best practice care coordination and care planning. Practices with a social worker on staff have a greater understanding of, and linkage with, community services. The current MCH Strategic Plan calls for improved linkages between CYSHCN social workers at the Health Department and within medical homes. This priority reflects a major transformation in the role of the Health Department's CYSHCN program away from providing direct clinical services. Key informants stated that these connections are intended to increase the focus on children in the community health team model, which has previously been very adult focused.

Help Me Grow, the State Implementation Grant for Systems of Services for CYSHCN (D70), enhanced Early and Periodic Screening, Diagnosis and Treatment (EPSDT) efforts, and statewide home visiting standards also are positioning Vermont to make major strides in this measure.

Cultural competence is also central to the effectiveness of a medical home. Key informants described how, with the influx of immigrants and refugees, the state quickly had to recalibrate systems, change programs and practices, and become more responsive to a population of growing diversity. Key informants noted that there is more work to be done to overcome geographic variation in the system's level of cultural competence. Collaborative relationships with the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program has increased aspects of the state's capacity, as have the VFN's annual conference, classes provided to medical students at UVM School of Medicine, and trainings offered through VCHIP. All these activities help strengthen the current workforce as well as prepare those entering the workforce.

Transition from Pediatric to Adult Care. In 2009-2010, slightly over half (51.8%) of Vermont youth with special health care needs received the services necessary to make appropriate transitions to adult health care work and independence (NS-CSHCN). The Vermont rate exceeded the HP2020 target rate of 45.3% and the overall U.S. rate of 40.0%. However, wide variation in the rate of successful transition was reported between those with private insurance (66.0%) compared to those with Medicaid (39.4%). (National Survey of Children Special Health Care Needs)

Key informants noted many systems weaknesses and opportunities for improvement in transitioning from pediatric to adult care. Firstly, pediatricians experience difficulty identifying adult providers willing to take on transitioning young adults. Secondly, the adult system is not able to provide the same level of home and community-based support provided by schools. Thirdly, there is no systematic process to assist families in finding appropriate services. Variation in system capacity across the state, particularly in terms of specialty care, also was noted. For example, in Vermont, the number of autism diagnoses among children and youth has increased, but the state's capacity to respond has not. Quality improvement efforts currently are underway to address some of these issues.

Cross-Cutting/Life Course

Oral Health. In 2011, 56.6% of Vermont women had a dental visit during pregnancy (PRAMS). Younger women had fewer dental visits than older women. Less than half (43%) of women 19 years of age and younger had a dental visit while pregnant compared to over two thirds (69.2%) of women aged 36 and older. The act of having a dental visit during pregnancy also varied by maternal education, marital status

and type of insurance. Those with more than 12 years of education and married women had higher rates, while Medicaid recipients had significantly lower rates. (Pregnancy Risk Factor Surveillance System)

Vermont children and youth, aged 1-17 years, were more likely to have had a preventive dental visit in the past year than children in the U.S. overall (NSCH). In 2011-2012, 87.8% of Vermont children had a preventive dental visit in the past year compared to 77.2% of U.S. children. However, younger children were found to visit the dentist less often than older ones; 67.1% of Vermont children aged 1-5 years visited a dentist compared to 96.5% of children 6-11 years of age.

While key informants agreed that overall access to dental care and dental insurance coverage is relatively good for Vermont's children, they acknowledged that children living in certain rural areas of the state and some adults experience challenges in accessing dental care. Dentists are scarce in many rural areas and some providers limit the number of Medicaid or new Medicaid patients they will see. In recent years, Vermont has worked to expand the Medicaid dental benefit for pregnant women and women up to 60 days postpartum, removing the cap on the amount of dental coverage. While coverage for pregnant women has improved, use of coverage remains low. Preliminary analysis of claims data indicate that less than half of pregnant Medicaid beneficiaries accessed dental care. The Department of Health is working with Medicaid to identify barriers that limit utilization of dental services. These include a need to increase awareness of the dental benefit among pregnant women, and encouraging providers to use a code modifier that allows services to pregnant women to be reimbursed beyond the standard adult cap.

The surveillance data indicate a gap in meeting the American Academy of Pediatrics (AAP) guideline that children begin dental care at age one. Key informants felt this was due, in part, to a lack of knowledge of the guideline among medical and dental providers, and because Vermont has very few pediatric dentists. Strategies to address the shortfalls include promoting the AAP guideline to all providers and improving the capacity and skills of general dentists to serve very young children.

Seven of Vermont's Federally Qualified Health Centers (FQHC) facilitate access to dental care through an on-site dental clinic. All women who get their prenatal care at Community Health Center of Burlington (CHCB) are referred to the dental clinic. The Community Health Center also has a school-based dental clinic that serves thousands of children in the Burlington school system. Key informants regarded this is an exemplary model to increase access to dental care.

The Health Department continues to expand its Public Health Dental Hygienist (PHDH) program. Currently there are five dental hygienists embedded within WIC offices throughout the state. Additional initiatives to expand access to dental care in Vermont include the Tooth Tutor program; Medicaid reimbursement to medical providers for fluoride varnish application and oral health risk assessment; and Vermont's provision to allow hygienists to provide preventive care within schools, WIC, and other community settings under dental provider supervision. A bill introduced during the 2015 Vermont legislative session proposed to increase access to basic dental care services by expanding the scope of practice for mid-level dental providers. The bill did not pass, but we are hopeful that it will be reintroduced in 2016.

Additional challenges to improving oral health and access to dental care in Vermont include: lack of coordination between the medical and dental communities, difficulty in reaching and engaging the obstetric community, and attitudes and beliefs that that foster opposition to community water fluoridation.

Smoking. From 2009-2013, Vermont's rate of smoking during pregnancy was significantly higher than the U.S. rate (PRAMS). In 2013, Vermont's rate was 18.3% compared to the overall U.S. rate of 8.5%. While the U.S. rate is decreasing by 0.2% per year, there has been no significant change in the Vermont rate over the same time period. Only in college educated new mothers and those with private insurance has Vermont mirrored the national trend, with a decline in smoking of 0.9% and 1.0%, respectively. Nearly half (48%) of Vermont women with less than a high school diploma reported smoking during pregnancy, compared to 35.1% of those who graduated from high school and 17.0% of women with some college.

Somewhat surprisingly, the rate of second-hand smoking exposure among children in Vermont is not significantly different from the overall U.S. rate. There has been a significant yearly decrease in the U.S. exposure rates, together with a significant reduction between 2003 and 2011-2012 in Vermont. (National Survey of Children's Health) Children with special health needs are more likely to be exposed to smoking (29.8%) than children without a special health need (19.3%). Just as the rates reported for smoking during pregnancy decline with increasing education, so does the rate of exposure to second hand smoke. A 58.6% exposure rate was reported for children of women with less than high school education, compared to 9.2% of those born to college graduates.

In general, Vermont has good resources in place to support smoking cessation. Screening for tobacco use and associated referrals are incorporated in the Centers for Medicare and Medicaid (CMS) meaningful use measures, and tobacco cessation counseling is covered by Vermont Medicaid. However, smoking rates during pregnancy remain high in Vermont despite efforts to address this over the past several years. The Department of Health supports ongoing interventions to address smoking among pregnant women. The Tobacco Control Program collaborates with the MCH Division to address this issue through the infant mortality CoIIN. A statewide smoking cessation program called 802Quits provides cash rewards and free nicotine replacement therapy to pregnant women who participate in the program.

Key informants felt that tobacco cessation is not afforded a sufficiently high priority among health and human service providers. They recommended that more effort be put into engaging the obstetrics provider community. Concern also was expressed about the attitude of providers to tobacco use who treat women for other addictions such as opiate use. Tobacco use is often considered a lower priority, possibly due to it being legal and less social stigma being associated with its use. The CEASE (Clinical Effort Against Secondhand Smoke Exposure) program has been proposed as a strategy to address smoking among parents through counseling, nicotine replacement therapy and referrals to 802Quits by their child's pediatrician. The Health Department currently is exploring the possibility of reimbursing pediatricians who provide parent screening and referral. In addition, the Department's home visiting programs and the WIC program are proven strategies to improve cessation rates among pregnant and parenting women, and their families.

Adequate Health Insurance Coverage. Vermont is a national leader in the provision of health care access and insurance coverage for children and pregnant women. Almost nine out of ten Vermont children (89.0%) aged 0-5 years, and 79.7% of youth aged 12-17 years, were reported to have adequate insurance children in the 2011-2012, significantly higher than the overall U.S. rates of 80.7%. and 73.2%, respectively. (NSCH) However, there is concern that underinsured families may forego preventive care due to high deductibles or co-payments. Similar concerns are raised about discontinuities in health insurance coverage due to change of circumstance. For example, individuals enrolled in the state's Vermont Health Connect who have a change in their employment status may experience a lapse in coverage. Medicaid is exploring policy options to ensure that people can maintain their insurance coverage despite certain changes in circumstances.

For the families of children and youth with special health care needs, insurance continues to be a significant challenge. Key informants qualify this issue by noting it is not necessarily due to a lack of coverage but rather difficulty in understanding the system and its complexity. This uncertainty leads to anxiety and frustration as families spend significant time navigating the system. Informants add that some families may resort to paying expenses out-of-pocket because their questions remain unresolved and their needs unmet. Recognizing that coverage alone may not be the principle barrier, the Health Department's CSHN program created a Health Services Training and Technical Assistance position. The person in this position is supports families and helps them to understand the coverage available.

With implementation of the ACA, there has been a significant drop in the rate of those who are uninsured. [Update] Act 48 of the 2011 legislative session established Green Mountain Care (GMC) as a universal, publically financed health coverage program available to all Vermonters. GMC was originally intended to cover all residents, except those who have coverage from Medicare or TRICARE. The State estimated that initially 519,000 Vermonters would be covered by GMC in the first year, with 538,000 covered by the fifth year. GMC, as it was envisioned, would have provided a wide array of benefits, consistent with the coverage most employers provide today, and include primary, preventive and chronic care, urgent care and hospital services. Included in these benefits would be vision and dental care for Vermonters up to age 21, as required by the ACA. However, GMC would not cover long-term care, services and supports. In December 2014, the Governor announced that he could no longer recommend that the legislature move forward with public financing for GMC. A revised course was adopted that took into account the prevailing economic climate, additional cost factors, and a risk of economic shock that was judged to be unacceptably high at that time.

Nevertheless, access to the health care system is relatively well-addressed in Vermont compared to other states. Vermont has high quality insurance coverage for all children in the state; Vermont has a widely distributed network of primary care providers throughout the state; and Vermont has a common belief in the medical home model. With these foundational supports in place, the primary focus on quality improvement to the MCH system in Vermont seeks to better address systems and care coordination.

Title V Program Capacity

Organizational Structure. Vermont's Title V agency is the Division of Maternal and Child Health, which sits within the Vermont Department of Health, overseen by the Commissioner of Health, Dr. Harry Chen. The Health Department is part of the Agency of Human Services, enjoying joint leadership and close partnerships with five other departments: the Mental Health, Health Access (Medicaid and health reform), Disabilities, Aging, and Independent Living, Children and Families, and Corrections. The Secretary of Human Services, Hal Cohen, reports directly to the Governor.

The MCH Division, led by Dr. Breena Holmes since 2010, has primary oversight for all Title V programs. A number of other federal initiatives are housed within the MCH Division, including: WIC administration; Maternal, Infant, Early Childhood Home Visiting (MIECHV); Linking Actions for Unmet Needs in Children's Health (LAUNCH); Title X family planning; PREP pregnancy prevention; EPSDT, including school health; and significant pieces of the Race-to-the-Top Early Learning Challenge. Vermont's Children with Special Health Needs (CSHN) program also is under the MCH Division umbrella.

The MCH Division works very closely with other divisions within the Department of Health to carryout activities related to Title V. Vermont does not have county level health departments, but local offices at

the district level. MCH Coordinators and School Liaisons in each of these district offices carry out Title V and other MCH-related work within communities, in partnership with MCH. The Division of Health Promotion and Disease Prevention houses program activities related to tobacco control and prevention, oral health, physical activity and nutrition, and chronic disease. MCH works with the Division of Emergency Preparedness, Response and Injury Prevention to address childhood injury and Environmental Health around toxic exposure. MCH epidemiology, data analysis, and surveillance is conducted by staff within the Division of Health Surveillance, as is our state immunization program.

Agency Capacity. Vermont's Title V agency is exceptionally well positioned to promote and protect the health of all mothers and children, including CSHCN. Although small in size, the MCH Division is engaged in a multitude of initiatives across all six population domains. Core programs include: preconception health; family planning; adolescent pregnancy prevention; quality improvement work in obstetrical/gynecologic and reproductive practice (women's and maternal health); WIC; home visiting (perinatal, maternal and infant health); health in early care and education; Help Me Grow; EPSDT; quality improvement in pediatric practice (child health); school health; youth empowerment (adolescent health); and children with special health care needs. In addition, MCH supports ongoing cross-population initiatives in oral health, tobacco, mental health, trauma, substance abuse, and strengthening families.

Because of our small size, MCH staff have close and frequent contact with each other, with other divisions within the Health Department (chronic disease, environmental health, health surveillance), and with state and local health system, social service, and community partners. A more complete listing of these partners is described below.

Vermont's Title V program is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated, family-centered care. Vermont MCH is a central component of Integrating Family Services (IFS). IFS, in turn, is an innovative cross-department initiative within the Vermont's Agency of Human Services, which seeks to create a seamless integrated continuum of health services for all children and their families. IFS efforts are directed towards health promotion, prevention, and early intervention from providing intensive treatment to long term supports. The system is designed to provide integrated services and supports to the family unit, not just the child, ultimately improving the care experience and the effective use of resources. In this respect, IFS represents a major innovation and shift in the model of care delivery. Vermont's MCH Director is a member of the IFS Leadership team; staff from our CSHN program are part of the Implementation team; and regional MCH Coordinators are involved in activities at the local level.

Vermont has worked for more than a decade to build a unified, early care, health and education system. We made the commitment to develop a comprehensive system through the advancement of Building Bright Futures (BBF). BBF is an innovative public/private partnership comprised of private sector providers, families, business leaders, community members and state government decision makers. The organization is designed to create a unified, sustainable system of early care, health, and education for young children and their families to ensure that all Vermont children will be healthy and successful. A BBF Regional Council in each district brings together parents, service providers, employers and others at the community level to implement their Regional Plan for comprehensive early childhood services. The MCH Director is on the BBF Statewide Council and MCH Coordinators work closely with Regional Councils.

In addition, MCH is leading the implementation of *Help Me Grow* Vermont (HMG). Now replicated in 24 states, HMG provides a framework that integrates child health, early care and education and family support services. HMG is a comprehensive system that ensures that early detection leads to the linkage

of at-risk children and their families to community-based programs and services. Vermont will build on the HMG system to implement universal, early surveillance and screening for all children, including CSHN, and link them to existing quality programs and services, including a medical home.

In addition, Vermont MCH has been awarded a *State Implementation Grant for Enhancing the System of Services for Children and Youth with Special Health Care Needs through Systems Integration*. Through this process, Vermont's CSHN program is working to develop a State Plan and implement statewide strategies for improving the system of care.

Lastly, MCH leadership serves on numerous committees, boards, advisory councils, and task forces, with the express aim to improve the system of care and health outcomes for pregnant women and children, many of which are described in more detail below.

MCH Workforce Development and Capacity. Approximately 16.25 FTEs, representing 38 staff, work to implement Title V programming. These staff are located at the VDH central office in Burlington and in twelve district offices across the state. Altogether, there are 54 staff in the MCH Division (including CSHN). Additional staff in the Office of Local Health, including MCH Coordinators, School Liaisons, and WIC Nutritionists, carry out the work of MCH in their communities. Vermont has successfully leveraged Title V dollars by funding these positions through other federal grants and Vermont's Global Commitment Waiver.

The MCH Division is led by a team of professionals who contribute to Vermont's MCH planning, evaluation, and data analysis capabilities. Key informants noted that Vermont Title V has: "excellent leadership and organizational structure".

- Breena Holmes, MCH Director
- Ilisa Stalberg, MCH Deputy Director – strategic planning, liaison to office of local health, special projects
- Sally Kerschner, MCH Planner – programmatic leadership for injury, home visiting, early childhood
- Nathaniel Waite, Child Health Prevention Coordinator – programmatic leadership for EPSDT, school health
- Monica Ogelby, CSHN Director of Clinical Services – leadership for all CSHN programs
- Kim Bean, CSHN Operations Director – oversight of CSHN budget/business processes
- Carol Hassler, CSHN Medical Director and Child Development Clinic Director – Developmental Pediatrician
- Donna Bister, WIC Director – WIC leadership
- John Burley, Data Analyst – leadership for data integration across statewide home visiting programs
- Laurin Kasehagen, MCH Epidemiologist/CDC assignee
- Kat Seaton, MCH Division Administrator – oversight of MCH budget/business processes
- Kim Swartz, Director of Preventive Reproductive Health – programmatic leadership for preconception health, family planning, pregnancy prevention, and domestic and sexual violence
- Lisa Maynes, parent representative, VFN

The Vermont Title V program has no staff member serving specifically in the role of parent/family member.

A number of retirements in the MCH workforce may be anticipated over the next five years, including some in key MCH leadership positions. As staff retire, we will continue to examine MCH priorities and ensure that Title V and other MCH funds are directed towards these new and emerging priorities.

The Department of Health and our MCH Division is committed to identifying and addressing health disparities in a culturally competent manner. The department's strategic plan calls for "health equity for all Vermonters", and the following examples demonstrate implementation of this principle by MCH programs. The WIC program serves a diverse population in Burlington, including new American populations, and strives to do so in a culturally competent manner. A recent training, funded under the Autism State Implementation Grant (D70), provided training and concrete skill development related to cultural issues and developmental screening. Health disparity initiatives under the LAUNCH program are aimed at increasing effective, equitable, understandable, and respectful health care and services. The program seeks to increase responsiveness to diverse cultural beliefs and practices, preferred languages, health literacy and other communication needs through trainings and organizational assessments. The LAUNCH evaluator collaborates with the Diversitydatakids.org project based at the Heller School for Social Policy and Management, Brandeis University, to identify the most pressing children's health disparities in Vermont and to inform decision makers regarding strategic resource allocation and service priorities.

Many of our sub-recipient grants include mandatory language related to cultural competency, ensuring that the provision of quality pediatric services for Vermont children is delivered with flexibility and adaptability. The State and its sub-recipients are required to provide non-English speakers with access to interpreters and translated materials.

The Department of Health has a Refugee Health and Health Equity Coordinator who works statewide to ensure that departmental programs address health disparities. Our affirmative recruitment work group is committed to supporting the department in diverse hiring and retention practices. In 2014, departmental leaders participated in a five-day, intensive cultural competency workshop. By 2016, all new staff will be expected to complete cultural competency training within 60 days of hire. A department-wide work group is in the process of identifying all programmatic materials that need translation. Furthermore, a majority of reports and briefs published by the Department of Health incorporate data and analyses to evaluate the impact of programming on health disparities. Lastly, we are currently working on a plan that includes strategies and guidance to reduce barriers to health equity, to be finalized in 2016.

During key informant interviews, some stakeholders noted gains in the area of cultural competency and eliminating disparities while others noted that Vermont has a long way still to go. More training is needed to ensure that providers practice in a culturally competent manner. We also need to promote a more general awareness, understanding, and sensitivity towards Vermont populations that represent our social, economic, geographic, racial, ethnical, and cultural diversity. While the public and service providers are becoming more aware of the impact of social determinants of health and adverse childhood/family events (AFE), we now need to focus our work on prevention and intervention.

Partnerships, collaboration, and coordination – public, private, family

Vermont is a small rural state with a population of just over 600,000, and proportionally small state government agencies. Staff in state agencies serving children and families are committed to working closely with each other and with non-profit organizations to address the needs of Vermont children and families. Vermont has many strengths and is at the leading edge of significant innovation and

advancement in health care delivery and financing for Vermont's children, including those with special health care needs.

Children's Integrated Services. Children's Integrated Services (CIS) is situated in the Department for Children and Families, and operates under the umbrella of Integrating Family Services. This structure provides a continuum of prevention and early intervention services for eligible prenatal/postpartum women, infants and children 0-6 years and their families.

Vermont Child Health Improvement Program (VCHIP). VCHIP is a population-based, child and adolescent health services research and quality improvement program at the University of Vermont. VCHIP leads Vermont's improvement partnership and is convener of the National Improvement Partnership Network. The program works to build a shared vision of quality health care for children and families, and to facilitate cross-sector partnerships including researchers, practitioners, insurers, professional organizations, and government. VCHIP partners with Title V on an ongoing basis and has been a critical contributor to quality improvement and evaluation for many of our initiatives. Since 2000, the partnership between the MCH and VCHIP has resulted in measurable improvements in child health outcomes across the pediatric age spectrum and in a variety of health service areas.

American Academy of Pediatrics Vermont Chapter (AAPVT). The Department of Health collaborates with AAP Vermont to reduce barriers to health care for children receiving Medicaid/Dr. Dynasaur; to assist the Health Department in the development of more efficient and effective health care services for children and families through consultation with the health care professional community; and to identify and improve systems of care for children at risk.

For more than a decade, a monthly Primary Care and Public Health Integration meeting convenes the leadership of MCH, VCHIP, AAPVT, the Vermont chapter of the American Academy of Family Physicians (VT AAFP), Planned Parenthood of Northern New England, obstetricians and gynecologists, physicians, and primary care internal medicine providers. The goal of the group is to coordinate projects that cross organizational borders and that address key public health issues for children, adolescents, and young adults. A recent example was the formation of a subcommittee to organize partner efforts around improving HPV immunization rates.

Vermont Pediatric Council (VPC) is based upon a national model developed by the AAP. Its purpose is to foster enhanced communication among pediatricians, insurers, public health professionals and others committed to improving the health status of and health care for Vermont's children.

Agency of Education. Several times a year the MCH division convenes the school health team, with representation from the Agency of Education, to set shared priorities in school health. In addition, the state school nurse consultant – a member of the MCH staff – oversees the standards of practice and orientation for school nurses as well as promoting the school nurse leader model.

Leadership Education in Neurodevelopmental and Related Disabilities (LEND). This program provides a 9-month, graduate level, interdisciplinary training course to health professionals. It focuses on developing competencies in family-centered care, interdisciplinary collaborative teamwork, cultural competence, leadership, and knowledge and skill development in neurodevelopmental disabilities including autism spectrum disorder (ASD). Vermont Title V and CSHCN work closely and collaboratively with Vermont LEND across a broad range of initiatives.

Home Visiting Alliance (HVA). In 2012, a coalition of community and state agencies was created to provide leadership for collaboration and strengthening the system of Vermont's MCH home visiting programs. In 2013, the HVA supported the passage of state legislation (Act 66) that directs the state's agencies and home visiting stakeholders to: establish quality standards for programs; define outcomes that programs need to achieve; develop performance measures; improve training and professional development for home visitors; and create a coordinated system of resources and referral for families. Presently, the HVA is developing the procedures and common measurements as required by this legislation.

Vermont Family Network (VFN). Vermont has a long tradition of promoting family-centered care and involving families in all levels of decision making. For example, over the past five years families of children with ASD and adults with ASD have been very involved in the assessment of system needs and in the development of the State Autism Plan. Parents or parent representatives from family support organizations such as VFN are regular members of many state committees and advisory boards.

VFN is committed to a mission that promotes better health, education and well-being for all children and families, with a focus on children and young adults with special needs. VFN has membership on MCH's leadership team – providing leadership, strategic direction, action planning, and workforce development around all MCH content (including Title V performance measures) and all MCH competencies. VFN regularly participates in our annual Title V submission, needs assessment, and attends the state block grant review yearly.

Vermont's CSHN program has a longstanding history of supporting the ongoing work of VFN. Their work focuses on support for families of CSHN, as they face new diagnoses, crises, or transitions. Family Support Consultants (FSCs) develop and maintain close relationships with other family support agencies across Vermont to help disseminate information about services and supports available through each agency and the best contacts and resources in the community. Additionally, FSCs lead and mentor support groups, provide workshops and informational gatherings, and organize opportunities for families with CSHN to discuss their views with healthcare providers, policy-makers, and legislators. To broaden understanding of the family perspective, VFN encourages and develops family leaders. Family leaders are trained to use their stories and experiences to bring about change at all levels.

Hearing Advisory Council. Vermont's Hearing Advisory Council is the longest standing council hosted by the Department of Health. Its mission is to advise the Health Department on issues that impact deaf and hard of hearing children and their families. The council is comprised of professionals, parents and deaf and hard of hearing adults.

Newborn Screening Advisory Committee. Our newborn screening program requests input from professional and public stakeholders before any changes or additions are made to the program. This group of parents, providers, subspecialists, public health personnel and other interested parties meets on an ad-hoc basis to consider issues and make recommendations to the Health Commissioner. Newborn screening in Vermont is authorized through the Administrative Rules process.